

		FOR OHF USE					

LL 1

**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0042192</u></p> <p><b>Facility Name:</b> <u>Alden Orland Park Rehab &amp; HCC</u></p> <p><b>Address:</b> <u>16450 South 97th Ave.</u> <u>Orland Park</u> <u>60462</u>          Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(708) 403-6500</u> <b>Fax #</b> <u>(708) 873-9774</u></p> <p><b>IDPA ID Number:</b> <u>36-3901683</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>01/08/98</u></p> <p><b>Type of Ownership:</b></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steven M. Kroll</u> <b>Telephone Number:</b> <u>(773) 286-3883</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%;"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Steven M. Kroll</u></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Financial Officer</u></td> </tr> </table> <table border="1" style="width: 100%;"> <tr> <td rowspan="4" style="width: 20%;"><b>Paid Preparer</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td>(Telephone) <u>( )</u> Fax # ( )</td> </tr> </table> <p style="text-align: center;"><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____	(Type or Print Name) <u>Steven M. Kroll</u>		(Title) <u>Chief Financial Officer</u>	<b>Paid Preparer</b>	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>( )</u> Fax # ( )
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																	
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																	
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																	
	<input checked="" type="checkbox"/> "Sub-S" Corp.																																		
	<input type="checkbox"/> Limited Liability Co.																																		
	<input type="checkbox"/> Trust																																		
	<input type="checkbox"/> Other _____																																		
<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____																																		
	(Type or Print Name) <u>Steven M. Kroll</u>																																		
	(Title) <u>Chief Financial Officer</u>																																		
<b>Paid Preparer</b>	(Signed) _____ (Date) _____																																		
	(Print Name and Title) _____																																		
	(Firm Name & Address) _____																																		
	(Telephone) <u>( )</u> Fax # ( )																																		

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Alden Orland Park Rehab & HCC# 0042192 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>200</u>	Skilled (SNF)	<u>200</u>	<u>73,000</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>200</u>	TOTALS	<u>200</u>	<u>73,000</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,480</u>	<u>13,552</u>	<u>16,729</u>	<u>34,761</u>	8
9	SNF/PED					9
10	ICF	<u>4,854</u>	<u>8,306</u>	<u>428</u>	<u>13,588</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,334</u>	<u>21,858</u>	<u>17,157</u>	<u>48,349</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 66.23%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)none

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1/19/98

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 110 and days of care provided 16,615Medicare Intermediary AdminiStar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Alden Orland Park Rehab &amp; HCC

# 0042192

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	529,385	52,618	6,900	588,903	839	589,742		589,742			1
2	Food Purchase		381,149		381,149	(23,505)	357,644	190	357,834			2
3	Housekeeping	246,149	43,032		289,181	172	289,353		289,353			3
4	Laundry	85,394	14,212		99,606	85	99,691		99,691			4
5	Heat and Other Utilities			203,641	203,641		203,641	(1,201)	202,440			5
6	Maintenance	69,642		129,386	199,028	63	199,091	9,071	208,162			6
7	Other (specify):* security			91	91		91		91			7
8	<b>TOTAL General Services</b>	930,570	491,011	340,018	1,761,599	(22,346)	1,739,253	8,060	1,747,313			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			22,800	22,800		22,800		22,800			9
10	Nursing and Medical Records	2,566,959	151,912	11,378	2,730,249	3,595	2,733,844	(41,091)	2,692,753			10
10a	Therapy	110,028			110,028		110,028		110,028			10a
11	Activities	103,311	3,119	880	107,310	50	107,360		107,360			11
12	Social Services	46,181			46,181		46,181		46,181			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,826,479	155,031	35,058	3,016,568	3,645	3,020,213	(41,091)	2,979,122			16
	<b>C. General Administration</b>											
17	Administrative	148,871			148,871		148,871		148,871			17
18	Directors Fees											18
19	Professional Services			874,711	874,711	(10,175)	864,536	(818,314)	46,222			19
20	Dues, Fees, Subscriptions & Promotions			57,005	57,005		57,005	(48,202)	8,803			20
21	Clerical & General Office Expenses	403,219	20,030	74,349	497,598		497,598	72,517	570,115			21
22	Employee Benefits & Payroll Taxes			606,339	606,339	18,701	625,040	50,794	675,834			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,678	3,678		3,678	10,130	13,808			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			129,083	129,083		129,083	13,355	142,438			26
27	Other (specify):* bad debts			25,351	25,351		25,351	(25,351)				27
28	<b>TOTAL General Administration</b>	552,090	20,030	1,770,516	2,342,636	8,526	2,351,162	(745,070)	1,606,092			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,309,139	666,072	2,145,592	7,120,803	(10,175)	7,110,628	(778,101)	6,332,527			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number      Alden Orland Park Rehab & HCC      #0042192      Report Period Beginning:      01/01/2003      Ending:      12/31/2003

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			37,514	37,514		37,514	412,473	449,987			30
31	Amortization of Pre-Op. & Org.			733	733		733	87,352	88,085			31
32	Interest			200,066	200,066		200,066	1,315,771	1,515,837			32
33	Real Estate Taxes					10,175	10,175	410,307	420,482			33
34	Rent-Facility & Grounds			1,617,829	1,617,829		1,617,829	(1,617,829)				34
35	Rent-Equipment & Vehicles			13,960	13,960		13,960	18,672	32,632			35
36	Other (specify):* mort insurance							64,201	64,201			36
37	<b>TOTAL Ownership</b>			1,870,102	1,870,102	10,175	1,880,277	690,947	2,571,224			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		760,936	1,122,933	1,883,869		1,883,869	(66,639)	1,817,230			39
40	Barber and Beauty Shops	43,901			43,901		43,901		43,901			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	43,901	760,936	1,232,433	2,037,270		2,037,270	(66,639)	1,970,631			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,353,040	1,427,008	5,248,127	11,028,175		11,028,175	(153,793)	10,874,382			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number Alden Orland Park Rehab &amp; HCC

# 0042192

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	2,145	30		9
10 Interest and Other Investment Income	(422)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(4,705)	2		13
14 Non-Care Related Interest	(7,420)	32		14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees	(231)	21		17
18 Fines and Penalties				18
19 Entertainment	(160)	20		19
20 Contributions	(3,323)	20		20
21 Owner or Key-Man Insurance		20		21
22 Special Legal Fees & Legal Retainers	(12,244)	19		22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(25,351)	27		24
25 Fund Raising, Advertising and Promotional	(42,193)	20		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule				29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (93,904)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(58,417)	various	34
35 Other- Attach Schedule	(1,472)	pg 5a	35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (59,889)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (153,793)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39		x			39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

Alden Orland Park Rehab & HCC

ID# 0042192

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Late fees on utilities	\$ (4,219)	5	1
2				2
3				3
4	intercompany interest-GL 7031	(1,854)	32	4
5				5
6	Back out 30.13% of IHCA dues (PAC)	(2,983)	20	6
7	Back out marketing manager expense	(10,998)	21	7
8	Recl maint portion of vend sett fr ln 21 to 6	10,233	21	8
9	Recl maint portion of vend sett fr ln 21 to 6	(10,233)	6	9
10	Back out prior year vend settle (maint) cr activity	10,233	6	10
11	Back out prior year vend settle activity (g&a)	(78)	21	11
12	Offset p/r costs with misc income receipts (p/r)	(289)	22	12
13	Offset p/r costs with misc income receipts:Jury Duty	(52)	22	13
14	Offset legal fees with misc income for court fees	(2,194)	19	14
15	Back out deprec adj on prior year tub acquisition	11,946	30	15
16	Increase deprec on painting def maint item (last yr)	721	6	16
17	Marketing Employ.Benefits Deduction	(1,705)	22	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,472)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden Orland Park Rehab &amp; HCC

# 0042192

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,705)	0	0	4,895	0	0	0	0	0	0	0	190	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,219)	0	3,018	0	0	0	0	0	0	0	0	(1,201)	5
6	Maintenance	721	0	9,801	0	0	0	(25)	(1,426)	0	0	0	9,071	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(8,203)</b>	<b>0</b>	<b>12,819</b>	<b>4,895</b>	<b>0</b>	<b>0</b>	<b>(25)</b>	<b>(1,426)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8,060</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(39,621)	(1,470)	0	0	0	0	0	0	(41,091)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(39,621)</b>	<b>(1,470)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(41,091)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,438)	17,469	(821,345)	0	0	0	0	0	0	0	0	(818,314)	19
20	Fees, Subscriptions & Promotions	(48,659)	0	457	0	0	0	0	0	0	0	0	(48,202)	20
21	Clerical & General Office Expenses	(1,075)	0	26,905	25,920	20,767	0	0	0	0	0	0	72,517	21
22	Employee Benefits & Payroll Taxes	(2,046)	0	48,107	0	4,733	0	0	0	0	0	0	50,794	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	10,130	0	0	0	0	0	0	0	0	10,130	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	13,120	235	0	0	0	0	0	0	0	0	13,355	26
27	Other (specify):*	(25,351)	0	0	0	0	0	0	0	0	0	0	(25,351)	27
28	<b>TOTAL General Administration</b>	<b>(91,568)</b>	<b>30,589</b>	<b>(735,511)</b>	<b>25,920</b>	<b>25,500</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(745,070)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(99,771)</b>	<b>30,589</b>	<b>(722,692)</b>	<b>(8,806)</b>	<b>24,030</b>	<b>0</b>	<b>(25)</b>	<b>(1,426)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(778,101)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Alden Orland Park Rehab &amp; HCC

# 0042192

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	14,091	385,977	10,584	0	1,821	0	0	0	0	0	0	412,473 30
31	Amortization of Pre-Op. & Org.	0	85,747	1,362	0	0	243	0	0	0	0	0	87,352 31
32	Interest	(9,696)	1,282,934	40,261	0	1,904	368	0	0	0	0	0	1,315,771 32
33	Real Estate Taxes	0	403,856	5,659	0	792	0	0	0	0	0	0	410,307 33
34	Rent-Facility & Grounds	0	(1,617,829)	0	0	0	0	0	0	0	0	0	(1,617,829) 34
35	Rent-Equipment & Vehicles	0	0	18,672	0	0	0	0	0	0	0	0	18,672 35
36	Other (specify):*	0	64,201	0	0	0	0	0	0	0	0	0	64,201 36
37	<b>TOTAL Ownership</b>	<b>4,395</b>	<b>604,886</b>	<b>76,538</b>	<b>0</b>	<b>4,517</b>	<b>611</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>690,947 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	(66,553)	(88,889)	88,803	0	0	0	0	0	(66,639) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(66,553)</b>	<b>(88,889)</b>	<b>88,803</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(66,639) 44</b>
	<b>GRAND TOTAL COST</b>												
45	(sum of lines 29, 37 & 44)	(95,376)	635,475	(646,154)	(75,359)	(60,342)	89,414	(25)	(1,426)	0	0	0	(153,793) 45



Facility Name &amp; ID Number Alden Orland Park Rehab &amp; HCC

# 0042192

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	See page 6k		See pg 6k		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Lease revenue	\$ 1,617,829	Orland Associates Limited Partnership	100.00%	\$	\$ (1,617,829) 1
2	V	32 interestr-income-tenant	165,327	Orland Associates Limited Partnership			(165,327) 2
3	V	19 Accounting fees		Orland Associates Limited Partnership		4,269	4,269 3
4	V	19 Misc admin. Fees		Orland Associates Limited Partnership		13,200	13,200 4
5	V	32 Prepaid financing interest charge		Orland Associates Limited Partnership		511,498	511,498 5
6	V	33 Real estate tax expense		Orland Associates Limited Partnership		403,856	403,856 6
7	V	26 Insurance expense		Orland Associates Limited Partnership		13,120	13,120 7
8	V	32 interest expense		Orland Associates Limited Partnership		937,590	937,590 8
9	V	36 Mortgage insurance expense		Orland Associates Limited Partnership		64,201	64,201 9
10	V	30 Depreciaiton		Orland Associates Limited Partnership		385,977	385,977 10
11	V	31 Amortization		Orland Associates Limited Partnership		85,747	85,747 11
12	V	32 Interest income-non-related party	827	Orland Associates Limited Partnership			(827) 12
13	V						
14	Total		\$ 1,783,983			\$ 2,419,458	\$ * 635,475 14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Orland Park Rehab &amp; HCC

# 0042192

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 employee benefit	\$	Alden Management Services, Inc.	0.00%	\$ 48,107	\$ 48,107	15
16	V	19 professional fee	834,739	Alden Management Services, Inc.		13,394	(821,345)	16
17	V	21 gen'l & admin		Alden Management Services, Inc.		26,905	26,905	17
18	V	5 utility		Alden Management Services, Inc.		3,018	3,018	18
19	V	6 maintenance		Alden Management Services, Inc.		9,801	9,801	19
20	V	24 travel & seminar		Alden Management Services, Inc.		10,130	10,130	20
21	V	26 insurance		Alden Management Services, Inc.		235	235	21
22	V	20 dues & subscriptions		Alden Management Services, Inc.		457	457	22
23	V	30 depreciation		Alden Management Services, Inc.		10,584	10,584	23
24	V	31 amortization		Alden Management Services, Inc.		1,362	1,362	24
25	V	33 real estate tax		Alden Management Services, Inc.		5,659	5,659	25
26	V	35 rent-equip & vehicles		Alden Management Services, Inc.		18,672	18,672	26
27	V	32 interest		Alden Management Services, Inc.		40,261	40,261	27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 834,739			\$ 188,585	\$ * (646,154)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Orland Park Rehab &amp; HCC

# 0042192

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 tube-feeding	\$ 11,791	Pyramid Health Care	0.00%	\$ 16,686	\$ 4,895	15
16	V	10 nursing saupplies	45,241	Pyramid Health Care		5,620	(39,621)	16
17	V	39 per diems/other supplies	144,680	Pyramid Health Care		78,127	(66,553)	17
18	V	21 gen'l & admin		Pyramid Health Care		25,920	25,920	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 201,712			\$ 126,353	\$ * (75,359)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Orland Park Rehab &amp; HCC

# 0042192

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 drugs	\$ 311,875	Forum Extended Care II	0.00%	\$ 263,475	\$ (48,400)	15
16	V	10 house stock	9,468	Forum Extended Care II		7,998	(1,470)	16
17	V	39 I. V.	260,902	Forum Extended Care II		220,413	(40,489)	17
18	V	22 employee beenefits		Forum Extended Care II		4,733	4,733	18
19	V	21 gen' & admin		Forum Extended Care II		20,767	20,767	19
20	V	32 interest		Forum Extended Care II		1,904	1,904	20
21	V	33 real estate tax		Forum Extended Care II		792	792	21
22	V	30 depreciation		Forum Extended Care II		1,821	1,821	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 582,245			\$ 521,903	\$ * (60,342)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Orland Park Rehab &amp; HCC

# 0042192

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 therapy	\$ 1,078,740	Community Physical Therapy	0.00%	\$ 1,167,543	\$ 88,803	15
16	V	32 interest		Community Physical Therapy		368	368	16
17	V	31 amortization		Community Physical Therapy		243	243	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,078,740			\$ 1,168,154	\$ * 89,414	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Orland Park Rehab &amp; HCC

# 0042192

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 repairs and maintenance	\$ 7,700	Alden Bennett Construction		\$ 7,675	\$ (25)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 7,700			\$ 7,675	\$ * (25)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Orland Park Rehab &amp; HCC

# 0042192

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 CARPET CLEANING	\$ 17,160	ALDEN REALTY - CARPET CARE		\$ 15,969	\$ (1,191)	15
16	V	6 FLOOR CLEANING	4,145	ALDEN REALTY - FLOOR CARE		3,910	(235)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 21,305			\$ 19,879	\$ * (1,426)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

Page 6K

Facility Name &amp; ID Number ALDEN NURSING CENTER - ORLAND PARK

# 004-2192

Report Period Beginning 01/01/03

Ending: 12/31/03

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Lincoln Park	Chicago
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomington
ANC Village for Children & Young Adults	Bloomington
ANC Waterford	Aurora
ANC Princeton	Chicago
Alden of Old Town East	Bloomington
Alden of Old Town West	Bloomington
Alden Trails	Bloomington
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
ANC Governors Park	Barrington

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living



## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	Chief Executive	100.00	330,865	1.812	4.53	Salary	\$ 15,687	17-1	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	0.00	83,124	1.812	4.53	Salary	3,941	10-1	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.00	80,383	1.812	4.53	Salary	3,811	6-1	3
4	Joan Carl d.	Secretary	Vice-President	0.00	208,259	1.812	4.53	Salary	9,876	17-1	4
5	see others attached on page 7A			0.00	590,010				27,974		5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10	d. Joan Carl is the Secretary of Alden Management Services and all nursing facilities. She has an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12											12
13								TOTAL	\$ 61,289		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2	Ami Pissetzki	investor relations	invest/bank		187,480	1.812	4.53	Salary	8,889	17-1	2
3	Bob Molitor	Vp of Operations	operations		208,311	1.812	4.53	Salary	9,877	17-1	3
4	Mary Chelotti Smith	In-house counsel	legal advis.		194,219	1.812	4.53	Salary	9,208	21-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 27,974		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Orland Park Rehab & HCC # 0042192 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, Inc.  
 Street Address 4200 W. Peterson Ave.  
 City / State / Zip Code Chicago, IL 60646  
 Phone Number ( 773 ) 286-3883  
 Fax Number ( 773 ) 286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<a href="#">see page 8A...</a>				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Prudential		X	Mortgage-refinanced		1/1/98	\$ 12,105,000	\$	6/30/37	7.7500	\$ 164,390	1	
2	Prudential		X	Operations-refinanced		12/00	2,563,300		5/1/37	7.6000	64,395	2	
3	Cambridge		x	Mortgage	\$66,014.00	5/2003	12,105,000	12,054,576	4/2043	5.9300	545,231	3	
4	Cambridge		x	Operations	\$13,979.00	4/2003	2,563,300	2,552,622	4/2043	5.9300	163,575	4	
5	Prudential		x	Payoff old Prudential loans							511,498	5	
	Working Capital												
6	related party-Ams	x		working capital							40,261	6	
7	related party-CPT & FECII	x		working capital							2,272	7	
8	Leumi	x		working capital	interest only	3/13/03	1,000,000	645,380	3/13/04	5.2500	25,465	8	
9	TOTAL Facility Related					\$79,993.00		\$ 30,336,600	\$ 15,252,579			\$ 1,517,086	9
	B. Non-Facility Related*												
10	Back out non-related party interest income on OP Assoc (165,327 of 166,154)										(827)	10	
11	Offset corp interest expense with interest income (gl 4646&4975)										(422)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related							\$	\$			\$ (1,249)	14
15	TOTALS (line 9+line14)							\$ 30,336,600	\$ 15,252,579			\$ 1,515,837	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 64,201 Line # 36

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name &amp; ID Number Alden Orland Park Rehab &amp; HCC

# 0042192 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$	488,700	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	441,156	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(47,544)	3	
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	451,400	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	10,175	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	414,031	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1998	132,526	8		
	1999	241,106	9		
	2000	355,797	10		
	2001	474,443	11		
	2002	438,258	12		
2. An adjustment for 2001 was billed and paid for in 2003 for \$2,898.					
4. current year accrual is based on a 3% increase over prior year's bill.					
				13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

## NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Alden Orland Park Rehab & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042192

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3742

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>27-21-401-003-0000</u>	<u>nursing home facility</u>	\$ <u>438,258.00</u>	\$ <u>438,258.00</u>
2. _____	<u>related party-Ams</u>	\$ <u>125,008.00</u>	\$ <u>5,659.00</u>
3. _____	<u>related party-Forum</u>	\$ <u>8,317.00</u>	\$ <u>792.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>571,583.00</u></u>	\$ <u><u>444,709.00</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   x   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
92,048

B. General Construction Type:

Exterior
brick

Frame
steel

Number of Stories
3

C.
Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
Does the Operating Entity?

☐ (a) Own the Equipment
☐ (b) Rent equipment from a Related Organization.
☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	nursing hom	350,871	1997	\$ 584,920	1
2					2
3	TOTALS	350,871		\$ 584,920	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	\$ 15,909	\$	22	\$	\$	\$ 15,909	4
5											5
6	200		1998	1997	12,679,210	314,835	40	316,980	2,145	1,900,399	6
7											7
8											8
9	Improvement Type**										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



## STATE OF ILLINOIS

Page 12A

Facility Name &amp; ID Number Alden Orland Park Rehab &amp; HCC

# 0042192

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	RUN CABLE TO BUILDING/INSTALL 6 OUTLETS	1998	\$ 2,975	\$ 297	10	\$ 297	\$	\$ 1,711		37
38	RELOCATION OF OUTLETS & POWER CIRCUIT	1998	1,648	165	10	165		975		38
39	INSTALL 6 WALL JACKS	1998	2,158		5			2,158		39
40	INSTALL CABLE	1998	4,446	445	10	445		2,667		40
41	REPLACE SPRINKLER HEADS	1998	6,236	624	10	624		3,482		41
42	INSTALL WALL PLATES	1998	4,608	384	5	384		4,608		42
43	Climate Service(boiler maintenance)	1999	14,529	726	20	726		3,632		43
44	Directional Boring(sprinkler system)	1999	5,400	360	15	360		1,740		44
45	Chicago Cooling(a/c unit repair)	1999	2,070	138	15	138		632		45
46	Church Landscape(floating swan island)	1999	3,400	680	5	680		3,003		46
47	Church Landscape(floating swan island)	1999	2,000	400	5	400		1,766		47
48	Watermangement(compressor)	1999	2,625	175	15	175		773		48
49	New Horizons Communications (light telephone sys)	2000	9,767	977	10	977		3,907		49
50	New Horizons Communications (light telephone sys)	2000	7,765	777	10	777		3,106		50
51	System Electric (wiring)	2000	1,384	69	20	69		277		51
52	Climate Services ( pipe )	2000	1,674	84	20	84		335		52
53	Climate Services ( pipe )	2000	1,689	84	20	84		338		53
54	Climate Services ( pipe )	2000	1,684	84	20	84		337		54
55	Climate Services ( pipe )	2000	2,376	119	20	119		475		55
56	GT Mechanical (heating/compressor repair )	2000	5,079	508	10	508		2,031		56
57	New Horizons Communications (light telephone sys)	2000	7,765	776	10	776		3,106		57
58	Alden Bennett Cons (time and billing material)	2000	2,073	207	10	207		691		58
59	Alden Bennett Cons (time and billing material)	2000	2,798	280	10	280		863		59
60	New Horizons Comm. (phone insall)	2000	4,437	444	10	444		1,775		60
61	Fox Valley Fire & Safety (sprinkler system)	2000	2,290	153	15	153		484		61
62	Alden Bennett Construction (time and material)	2000	2,915	291	10	291		899		62
63	Capps Plumbing (srvc/repair pump)	2001	1,977	132	15	132		362		63
64	Alden Bennett Construction (paving)	2001	9,328	622	15	622		1,296		64
65	Capps Plumbing (repair pump)	2002	7,214	481	15	481		1,844		65
66	Med-Con (alarm system)	2002	813	81	10	81		135		66
67	Alden Bennett Construction (time & material)	2002	4,008	267	15	267		445		67
68	Alden Bennett Construction (time & material)	2002	2,809	187	15	187		328		68
69	Alden Bennett Construction (time & material)	2002	2,365	158	15	158		289		69
70	TOTAL (lines 4 thru 69)		\$ 12,829,422	\$ 326,010		\$ 328,155	\$ 2,145	\$ 1,966,778		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 12,829,422	\$ 326,010		\$ 328,155	\$ 2,145	\$ 1,966,778	1
2	Alden Bennett Cons.-2002 cost adjustment	2003	(4,558)	(481)	15	(481)		(481)	2
3	Alden Bennett Cons..auto. Door opener	2003	3,915	196	10	196		196	3
4	Alden Bennet Cons. laundry press/gas/ellec	2003	6,825	455	15	455		455	4
5	GT Mechanical-repair heat pump	2003	1,797	329	5	329		329	5
6	CSI Coker-rebuild dishwasher	2003	4,333	253	10	253		253	6
7	Real Green-sprinkler system repair	2003	3,600	420	5	420		420	7
8	Real Green-sprinkler system repair	2003	1,750	263	5	263		263	8
9	CSI Coker kitchen exhaust pipe repair	2003	1,728	144	5	144		144	9
10	CSI Coker-walk in freezer repair	2003	1,560	130	5	130		130	10
11	Alden Bennett Cons.-ejector pump repair	2003	1,182	98	5	98		98	11
12	Controlled Irrigation-sprinkler systen repair	2003	2,552	170	5	170		170	12
13	Alden Bennett Cons-ejector pump repairs	2003	2,991	249	5	249		249	13
14	B&K Lawnsccaping-crushed stone walkway base	2003	1,400	12	10	12		12	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,858,497	\$ 328,248		\$ 330,393	\$ 2,145	\$ 1,969,016	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 12,858,497	\$ 328,248		\$ 330,393	\$ 2,145	\$ 1,969,016	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	16,755		20			16,755	4
5	Leasehold Improvement-Remodeling	1980	1,047		10			1,047	5
6	Leasehold Improvement-Remodeling	1986	559		5			559	6
7	Leasehold Improvement-Remodeling	1990	350		5			350	7
8	Leasehold Improvement-Remodeling	1991	82		5			82	8
9	Leasehold Improvement-Remodeling	1993	7,732		10			7,732	9
10	Leasehold Improvement-Remodeling	1993	6,056		9.7			6,056	10
11	Leasehold Improvement-sign	1994	226	14	12	14		120	11
12	Leasehold Improvement-dryvit	1995	384	24	10	24		203	12
13	Leasehold Improvement-new ac	1999	626	39	15	39		203	13
14	Leasehold Improvement-roof	1985	843	44	19	44		843	14
15	Leasehold Improvement-roof	1994	748	47	15	47		529	15
16	Leasehold Improvement-roof	1997	710	44	15	44		349	16
17	Leasehold Improvement-roof	1998	1,205	75	15	75		507	17
18	Leasehold Improvement-parking lot asphalt	2000	96	32	10	32		63	18
19	Leasehold Improvement-hallway lighting	2001	135	27	10	27		56	19
20	Leasehold Improvement-DAI	2001	169	17	10	17		53	20
21	Leasehold Improvement-bathrooms	2002	630	63	10	63		80	21
22	Leasehold Improvement-Remodeling	2002	91	18	5	18		36	22
23	Leasehold Improvements-Remodeling	2003	1,638	164	10	164		164	23
24	Leasehold Improvements-Remodeling	2003	105	4	4	4		4	24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	6,132		7			6,132	27
28	Leasehold Improvement-Remodeling	2002	5,020	627	7	627		4,392	28
29	Leasehold Improvement-Remodeling	2003	5,251	660	7	660		4,611	29
30									30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	15,137	378	40	378		1,896	33
34	TOTAL (lines 1 thru 33)		\$ 12,930,224	\$ 330,526		\$ 332,670	\$ 2,145	\$ 2,021,838	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,332,373	\$ 97,601	\$ 97,601	\$		\$ 556,380	71
72	Current Year Purchases	17,894	2,900	2,900			2,900	72
73	Fully Depreciated Assets	68,773	4,799	4,799			68,773	73
74								74
75	TOTALS	\$ 1,419,040	\$ 105,300	\$ 105,300	\$		\$ 628,053	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car engine/bus/van	:dodge/other	99-'03	\$ 11,860	\$ 2,052	\$ 2,052	\$	3	\$ 11,658	76
77	midwest transit	ford eldorado	2000	49,826	9,965	9,965		5	33,217	77
78										78
79										79
80	TOTALS			\$ 61,686	\$ 12,017	\$ 12,017	\$		\$ 44,875	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,995,870	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 447,842	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 449,987	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,145	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,694,766	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	n/a	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$ n/a	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: related party- cost is backed out

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 12,009 Description: copy machine \$11,133 & postage meter \$876

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>various</u>		\$	\$ <u>1,950</u>	17
18	<u>related party</u>	<u>various</u>	<u>1,556.00</u>	<u>18,672</u>	18
19					19
20					20
21	TOTAL		\$ <u>1,556.00</u>	\$ <u>20,622</u>	21

10. Effective dates of current rental agreement:

Beginning 4/1/96

Ending 12/31/05

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ 1,200,576

13. /2005 \$ 1,200,576

14. /2006 \$ 0

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input checked="" type="checkbox"/> NO	IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
		HOURS PER AIDE _____	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

skilled nurses on-site

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 540,875	\$		\$ 540,875	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			53,764			53,764	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			484,100			484,100	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see attached	# of prescrpts			228,383			228,383	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	see attached				510,108			510,108	13
14	TOTAL			\$		\$ 1,817,230	\$		\$ 1,817,230	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Alden Orland Park Rehab &amp; HCC

# 0042192

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 11,098	\$ 38,154	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,559,931	1,559,931	3
4	Supply Inventory (priced at )	51,676	51,676	4
5	Short-Term Investments			5
6	Prepaid Insurance	6,815	43,485	6
7	Other Prepaid Expenses	2,525	4,166	7
8	Accounts Receivable (owners or related parties)		1,121,687	8
9	Other(specify): Due from 3rd parties	126,016	136,594	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,758,061	\$ 2,955,693	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		584,920	13
14	Buildings, at Historical Cost		12,593,418	14
15	Leasehold Improvements, at Historical Cost	182,541	182,541	15
16	Equipment, at Historical Cost	276,161	1,343,291	16
17	Accumulated Depreciation (book methods)	(192,984)	(2,509,879)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	44,005	44,005	19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs	(733)	(733)	20
21	Restricted Funds		295,177	21
22	Other Long-Term Assets (spe financing fees, net		35,103	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 308,990	\$ 12,567,843	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,067,051	\$ 15,523,536	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,466,581	\$ 1,466,581	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	127,294	127,294	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	333,972	333,972	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	19,749	19,749	31
32	Accrued Real Estate Taxes(Sch.IX-B)		451,400	32
33	Accrued Interest Payable	22,260	94,444	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	accrued ins.,exps,idpa,sales tax,etc.	69,595	69,595	36
37	due to affiliates	2,402,803		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 4,442,254	\$ 2,563,035	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	719,580	719,580	39
40	Mortgage Payable		14,607,199	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 719,580	\$ 15,326,779	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 5,161,834	\$ 17,889,814	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (3,094,783)	\$ (2,366,278)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,067,051	\$ 15,523,536	48

\*(See instructions.)



XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,681,824)	1
2	Restatements (describe):		2
3	External audit adjustments made after 2001 cost report		3
4	was submitted. These have no effect on prior years report:		4
5	Bad debt, medicare revenues( non-allowables)	(301)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,682,125)	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	587,342	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 587,342	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (3,094,783)	24 *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 11,079,576	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 11,079,576	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	61,568	6
7	Oxygen	1,600	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 63,168	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	43,862	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	5,816	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,029	19
20	Radiology and X-Ray	220	20
21	Other Medical Services	43,315	21
22	Laundry	2,190	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 97,432	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	422	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 422	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	see Page 19A	2,986	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,986	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,243,584	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,761,599	31
32	Health Care	3,016,568	32
33	General Administration	2,342,636	33
<b>B. Capital Expense</b>			
34	Ownership	1,870,102	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,927,770	35
36	Provider Participation Fee	109,500	36
<b>D. Other Expenses (specify):</b>			
37	Related party salary allocations		37
38	transactions not included on this page, but included		38
39	on page 3&4.	(371,933)	39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,656,242	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	587,342	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 587,342	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name &amp; ID Number Alden Orland Park Rehab &amp; HCC

# 0042192

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,752	2,080	\$ 73,182	\$ 35.18	1
2	Assistant Director of Nursing	1,504	1,829	49,263	26.93	2
3	Registered Nurses	15,388	18,042	477,190	26.45	3
4	Licensed Practical Nurses	28,708	33,853	704,299	20.80	4
5	Nurse Aides & Orderlies	76,999	90,896	1,063,454	11.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,848	4,638	62,957	13.57	8
9	Activity Director	1,720	2,080	53,484	25.71	9
10	Activity Assistants	4,552	5,458	49,827	9.13	10
11	Social Service Workers	2,197	2,477	46,181	18.64	11
12	Dietician					12
13	Food Service Supervisor	2,816	3,288	48,887	14.87	13
14	Head Cook	5,008	6,000	85,982	14.33	14
15	Cook Helpers/Assistants	42,402	49,279	389,967	7.91	15
16	Dishwashers					16
17	Maintenance Workers	1,728	2,080	51,021	24.53	17
18	Housekeepers	21,145	24,984	239,342	9.58	18
19	Laundry	6,875	8,265	85,394	10.33	19
20	Administrator	1,720	2,080	85,189	40.96	20
21	Assistant Administrator					21
22	Other Administrative	4,095	4,940	104,516	21.16	22
23	Office Manager					23
24	Clerical	3,882	4,434	48,728	10.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,706	2,001	46,647	23.31	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,808	2,080	26,024	12.51	31
32	Other Health Care & CSS	8,491	9,946	145,671	14.65	32
33	Other(specify) Beautician Salaries	1,656	1,920	43,901	22.87	33
34	TOTAL (lines 1 - 33)	240,000	282,650	\$ 3,981,106 *	\$ 14.08	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	575/mo	\$ 6,900	1-3	35
36	Medical Director	1900/mo	22,800	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	400/mo	4,800	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	880	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	16	\$ 35,380		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ N/A		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name &amp; ID Number Alden Orland Park Rehab &amp; HCC

# 0042192

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function				Description			Description			
L. Kedrowski	administrator	0		\$ 85,189	Workers' Compensation Insurance	\$ 108,368		IDPH License Fee	\$		
					Unemployment Compensation Insurance	40,172		Advertising: Employee Recruitment		413	
					FICA Taxes	306,569		Health Care Worker Background Check		490	
					Employee Health Insurance	48,499		(Indicate # of checks performed <u>70</u> )			
various executives	executive				Employee Meals	23,505		II Health Care Assoc		6,917	
	management			63,682	Illinois Municipal Retirement Fund (IMRF)*						
					Union, health & welfare	56,775		Sec of State & surety bonds		200	
					Pension	28,794		various: internet subscriptions, etc		326	
TOTAL (agree to Schedule V, line 17, col. 1)				\$ 148,871	drug tests, 401k match, & vaccinations	9,690					
(List each licensed administrator separately.)					dental & life insur, relations, tuition, misc	2,667		related party		457	
B. Administrative - Other					Marketing Employ.Benefits Deduction	(1,705)		Less: Public Relations Expense	( )		
Description				Amount	Offset p/r costs with misc cash receipts(income)	(341)		Non-allowable advertising	( )		
				\$	related party	52,840		Yellow page advertising	( )		
					TOTAL (agree to Schedule V, line 22, col.8)	\$ 675,834		TOTAL (agree to Sch. V, line 20, col. 8)	\$	8,803	
TOTAL (agree to Schedule V, line 17, col. 3)				\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees					G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)					Description	Line #	Amount	Description		Amount	
C. Professional Services								Out-of-State Travel	\$		
Vendor/Payee	Type		Amount								
Alden Management	management fee		\$ 834,739					In-State Travel			
BDO Seidman	accounting fee		8,766					various auto & travel		889	
K. Fisch	legal fees		14,715					gas		427	
Greenburg & Hermann	legal fees		4,157					Seminar Expense			
Ams Legal	legal fees		1,000					Amex/II LTC/PES Healthcare		898	
Medicom	billing consult.		392					IHCA/Dr.Gore/		1,465	
Urban Real Estate	tax appraisal/assessment		3,000					related party		10,130	
Schmidt, Salzman	tax appraisal/assessment		7,175					Entertainment Expense	( )		
Cle.Ocu.	guardian filing fee		281					(agree to Sch. V, line 24, col. 8)			
Jennings/Dana	401k maint, etc		266					TOTAL	\$	13,808	
Talx Corp	unemployment consult		220								
					TOTAL	\$					
TOTAL (agree to Schedule V, line 19, column 3)				\$ 874,711							
(If total legal fees exceed \$2500 attach copy of invoices.)											

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
 (See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Boiler repair	11/98	\$ 1,672	3	\$ 557	\$ 465	\$ 0	\$	\$	\$	\$	\$	
2	Boiler maintenance/aj	2/99	2,073	3	691	691	58	0					
3	Heating repairs	12/99	1,797	3	599	599	549	0					
4	A W S DISTRUBUTING	2/00	3,093	3	1,031	1,031	1,031	0					
5	CLIMATE SERVICES (f	2/00	1,636	3	545	545	546	0					
6	GT MECHANICAL (sum	6/00	1,863	3	621	621	621	0					
7	CAPPS PLUMBING (four	3/00	2,781	3	773	927	927	154					
8	CAPPS PLUMBING (clea	3/00	1,460	3	406	487	487	80					
9	D.B.S CONTRACTING (r	7/00	2,790	3	930	930	930	0					
10	Painting > \$1,500 -1999	7/99	8,058	3	2,686	2,686	1,343						
11	Painting > \$1,500 -2000	7/00	4,336	3	723	1,445	1,445	723					
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 31,559		\$ 9,562	\$ 10,427	\$ 7,937	\$ 957	\$	\$	\$	\$	

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report?                       
If YES, give association name and amount. IHCA \$ 9900
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity?
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 7.5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,441 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease.
- (9) Are you presently operating under a sublease agreement?                      YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES                      NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 109,500  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 23,505 Has any meal income been offset against related costs? no Indicate the amount. \$ n/a
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? n/a If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
- c. What percent of all travel expense relates to transportation of nurses and patients? n/a
- d. Have vehicle usage logs been maintained? n/a
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
- g. Does the facility transport residents to and from day training? n/a**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a**
- (17) Has an audit been performed by an independent certified public accounting firm? no  
Firm Name: n/a The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. not required
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.

Alden Nursing Center - Orland Park  
Reporting Period Beginning  
Reporting Period Ending

# 004-2192  
1/01/03  
12/31/03

Page 25

Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2		(23,505)	Employee Meal
	22	23,505	Employee Meal
22		(5,342)	Uniforms
	10	4,133	Uniforms
	6	63	Uniforms
	4	85	Uniforms
	1	839	Uniforms
	3	172	Uniforms
	11	50	Uniforms
	21	0	Uniforms
19		(10,175)	R/E Tax Appeal
	33	10,175	R/E Tax Appeal
		<hr/> (0)	Net should be 0